OMNICARE HEALTH PLAN

Statutory Financial Statements

Year Ended December 31, 2000

(With Independent Auditors' Report Thereon)

OMNICARE HEALTH PLAN

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Independent Auditors' Report

The Board of Trustees
OmniCare Health Plan:

We have audited the accompanying statutory statement of admitted assets, liabilities, capital, and surplus of OmniCare Health Plan (Plan) as of December 31, 2000, and the related statutory statements of revenues and expenses and changes to capital and surplus, and cash flows for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

Except as discussed in the fourth and sixth paragraphs, we conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described more fully in note 1 to the financial statements, the Plan prepared these financial statements using accounting practices prescribed or permitted by the State of Michigan, Office of Financial and Insurance Services (the Office), which practices differ from accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between the statutory basis of accounting and accounting principles generally accepted in the United States of America also are described in note 1.

The accompanying financial statements have been prepared assuming that the Plan will continue as a going concern. As discussed in note 2 to the financial statements, the Plan has suffered recurring losses from operations and has a net capital deficiency. As a result of legal and statutory requirements, management is not able to provide us with all of the information deemed necessary with respect to the Plan's current operating status, and we were unable to obtain an evaluation of certain matters discussed in note 9 to the financial statements from the Plan's outside legal counsel. At December 31, 2000 these circumstances raise substantial doubt about the Plan's ability to continue as a going concern. The accompanying financial statements do not include any adjustments that might result from the outcome of this uncertainty.

As a result of legal and statutory requirements, the accompanying financial statements do not disclose certain information about the Plan's current operating status. In our opinion, disclosure of this information is required by the accounting principles prescribed by the Office.

As of December 31, 2000, the Company obtained an actuarially determined estimate of its medical claims payable. It was not practical to extend our auditing procedures sufficiently to satisfy ourselves as to the fairness of the assumptions used in determining such medical claims liability, stated at $25,500,000 in the accompanying financial statements as of December 31, 2000. Such amounts enter into the determination of financial position, results of operations, and cash flows.

Because we were unable to obtain certain information from the Plan's management and outside legal counsel, as discussed above in the fourth paragraph; and since we were unable to apply adequate procedures to the medical claims liability, as discussed in the sixth paragraph; and because of the significance of the uncertainty about the Plan's ability to continue as a going concern, as discussed in the fourth paragraph, we are unable to express an opinion on the accompanying financial statements.

KPMG LLP

May 18, 2001

OMNICARE HEALTH PLAN

Statutory Statement of Admitted Assets, Liabilities, Capital, and Surplus

December 31, 2000

(In thousands)

Assets

Current assets:		
Cash and cash equivalents	$	3,714
Short-term investments		49
Accounts receivable:		
Premiums		3,233
Providers		6,373
State of Michigan		3,254
Federal Employee Health Benefits Plan		804
Other		774
		14,438
Allowance for doubtful accounts		(2,386)
Accounts receivable, net		12,052
Due from affiliate		385
Other current assets		16
Total current assets		16,216
Investment in joint venture		358
Restricted investments – statutory reserves		1,082
Total assets	$	17,656

Liabilities and Net Deficit

Current liabilities:		
Medical claims payable	$	20,765
Accounts payable and accrued expenses		366
Due to affiliate		4,742
Total liabilities		25,873
Net worth (deficit):		
Surplus notes		17,300
Net deficit		(25,517)
Total net deficit		(8,217)
Total liabilities and net deficit	$	17,656

See accompanying notes to statutory financial statements.

OMNICARE HEALTH PLAN

Statutory Statement of Revenues and Expenses and Changes to Capital and Surplus

For the year ended December 31, 2000

(In thousands)

Revenues:	
Direct subscriber and commercial premiums earned	$ 55,010
Medicaid capitation	115,737
Net investment income and other	2,561
Total revenues	173,308
Operating expenses:	
Medical services:	
Inpatient	70,015
Emergency room and out-of-area	13,634
Physician services	38,985
Pharmacy	27,172
Other professional services	9,832
Reinsurance	532
Total medical services	160,170
Management fee	22,545
Total operating expenses	182,715
Other expenses, net	3,584
Change in net deficit	(12,991)
Net deficit – beginning of year	(7,576)
Issuance of surplus notes	12,700
Change in non-admitted assets	(350)
Net deficit – end of year	$ (8,217)

See accompanying notes to statutory financial statements.

OMNICARE HEALTH PLAN

Statutory Statement of Cash Flows

For the year ended December 31, 2000

(In thousands)

Operating activities:		
Change in net deficit	$	(12,991)
Adjustments to reconcile change in net deficit to net cash used in operating activities:		
Bad debt expense		2,951
Net realized losses		26
Equity in earnings of joint venture		(58)
Changes in operating assets and liabilities:		
Accounts receivable		5,422
Other current assets		(3)
Due from affiliate		(385)
Medical claims payable		1,470
Accounts payable and accrued expenses		(1,473)
Due to affiliate		2,380
Net cash used in operating activities		(2,661)
Investing activities:		
Purchases of investments		(942)
Proceeds from sales of investments		581
Net cash used in investing activities		(361)
Financing activities – issuance of surplus note		4,000
Net increase in cash and cash equivalents		978
Cash and cash equivalents at beginning of year		2,736
Cash and cash equivalents at end of year	$	3,714
Supplemental disclosure of non-cash investing and financing activities:		
Investing – conversion of management fee payable into a surplus note	$	3,700
Investing – conversion of medical claims payable into a surplus note		5,000

See accompanying notes to statutory financial statements.

(1) Organization and Summary of Significant Accounting Policies

(a) Organization

OmniCare Health Plan (the Plan), is a federally qualified, not-for-profit organization formed for the purpose of promoting and operating a health maintenance organization (HMO). As of December 2000, the Plan was providing health care services to approximately 100,700 covered members, primarily in Southeastern Michigan. The provider network for the Plan consists of 44 hospitals, more than 100 primary care locations, 2,300 physicians, and over 5,000 pharmacy locations. In September 2000, the Plan formally changed its name from Michigan HMO Plans, Inc. to OmniCare Health Plan.

OmniCare Plus, the Plan's point-of-service product, allows its members the choice of using either "in-network" health care providers or going "out-of-network" to fulfill health care needs. When -network" providers, a member receives health care services at little or no out-of-pocket cost. When using "out-of-network" providers, a member shares in the cost of the health care provided.

The Plan has a contract with the Michigan Department of Community Health (the Department) to provide health care services to Medicaid enrollees. This contract accounted for approximately 67% of the Plan's total revenues in 2000.

The Department awarded the Plan a new contract for the period beginning October 1, 2000 and ending on September 30, 2002, with the potential for three one-year contract extensions.

The Plan is managed by United American Healthcare Corporation (UAHC) pursuant to a management agreement (see note 8). Certain officers and shareholders of UAHC are officers of the Plan and members of the Plan's board of trustees.

(b) Basis of Presentation

The accompanying financial statements of the Plan have been prepared in accordance with the statutory accounting practices of the State of Michigan, Office of Financial and Insurance Services (the Office).

Prescribed statutory accounting practices include a variety of publications of the National Association of Insurance Commissioners (NAIC), as well as state laws, regulations, and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed.

The accounting practices applied in the preparation of the statutory financial statements vary in some respects from accounting principles generally accepted in the United States of America. Departures from accounting principles generally accepted in the United States of America affecting the Plan principally relate to certain assets and liabilities which are reflected as assets or liabilities under accounting principles generally accepted in the United States of America, but are excluded from assets and net worth or included as a component of net worth for statutory reporting purposes.

(c) Investment in Joint Venture

Investment in joint venture is accounted for under the equity method.

(d) Cash and Cash Equivalents

Cash equivalents include investments which are liquid and mature in three months or less when purchased, excluding funds maintained under statutory requirements, and consist of investments in short-term obligations, including money market funds, certificates of deposit, U.S. Government obligations, and demand obligations.

(e) Short-term Investments

Short-term investments consist of investments in debt securities with maturity dates of one year or less at the purchase date. Such investments are carried at cost less any valuation allowances and non-admitted amounts.

(f) Restricted Investments – Statutory Reserves

Amounts reserved pursuant to State of Michigan requirements are stated at cost less any valuation allowances and non-admitted amounts and consist of $1,082,000 of U.S. Government obligations. These amounts represent a contingency fund under an agreement with the Commissioner of Insurance, State of Michigan.

(g) Catastrophic Claims Receivable and Risk Sharing Reserve

Contracts with Individual Practice Associations (IPAs) provide for withholdings from capitation payments to create a reserve for catastrophic claims incurred by the providers. Ultimate claims clearing in excess of reserves are shared 50% between providers and the Plan. The Plan's management has implemented a plan to recover these amounts by additional withholding from capitation. These amounts are included in providers accounts receivable.

Contracts with IPAs provide for withholdings from capitation payments to create a reserve for risk sharing. The reserve is used to cover expenses incurred in the event of over-utilization of hospitalization and other medical services. The amounts retained are payable when the Plan's management determines that the remaining funds are not required to cover related costs.

In addition, the Plan renegotiated substantially all of its provider contracts with its IPAs. Contracts now specify that negotiated capitation payments be reserved in referral pools out of which medical claims are paid. Also, 10% of capitation payments are to be withheld as a reserve to cover referral pool deficits incurred in the event of overutilization of medical services. Deficits in excess of the 10% withheld are the sole liability of the Plan. In the event of a referral pool surplus, the 10% withheld and a maximum of 50% of the surplus is returned to the providers. These balances are included in medical claims payable.

(h) Medical Claims Payable

Medical claims payable include the cost of services for which providers have submitted claims, as well as management's estimate of the cost of claims that have been incurred but not reported (IBNR). The cost of claims that have been incurred but not reported has been estimated by management based on relevant industry data and historical trends. Management believes that methodologies employed to estimate the claim liability are reasonable and the claim liability recorded is appropriate. Adjustments to the medical claims payable are reflected in the statements of operations in the period in which such adjustments become known to management.

(i) Medical Services Expense

The Plan contracts with various health care providers for the provision of certain medical services to its members and generally compensates those providers on a capitated and fee-for-service basis.

(j) Premium Revenue

Membership contracts are negotiated on a yearly basis, subject to cancellation by the employer group or the Plan upon 30 days' written notice. Premiums are due monthly and are recognized as revenue during the period in which the Plan is obligated to provide services to members. Amounts collected in advance of the due date are recorded as a deferred premium revenue liability.

(k) Excess of Loss Reinsurance

The Plan has an agreement with an insurance company to provide reinsurance for subscribers' claims. After a deductible of $200,000 per member is reached, coverage under this agreement ranges between 70% and 90% of the excess eligible hospital services claims. The maximum lifetime reinsurance coverage for each member is $2 million.

Reinsurance premiums are reported as medical service expense, while the related reinsurance recoveries are reported as deductions from medical service expense.

(l) Tax Status

The Internal Revenue Service has ruled that the Plan qualifies as a tax-exempt entity under section 501(c)(4) of the Internal Revenue Code (IRC). Once qualified, the Plan is required to operate in conformity with the IRC to maintain its qualification. Plan management is not aware of any course of action or series of events that have occurred that might adversely affect the Plan's qualified status.

(m) Use of Estimates

The presentation of the financial statements in conformity with statutory accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported revenues and expenses during the reporting period. Actual results could differ from those estimates.

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(2) Liquidity

As of December 31, 2000, the Plan had a net worth deficit of approximately $8.2 million. Additionally, significant losses from operations resulted in negative working capital of $9.7 million at December 31, 2000. The minimum net worth requirement for the Plan at December 31, 2000 is $1.5 million, which is an increase from prior year's net worth requirement of $0.5 million. As a result, at December 31, 2000, the Plan was not in compliance with the State of Michigan's statutory net worth and working capital requirements.

In April 2000, the Plan issued a surplus note to UAHC in the amount of $7.7 million to assist the Plan in meeting its statutory net worth and working capital requirements at that time. The surplus note consisted of conversion of $3.7 million of management fee payable to UAHC and cash of $4.0 million. In addition, in November 2000, the Plan converted medical claims payable owed to the Detroit Medical Center (DMC) to a surplus note in the amount of $5.0 million.

Effective March 29, 2001, the Plan entered into a Letter of Intent (Letter) with the DMC, a provider hospital, and UAHC. The Letter, which is subject to DMC's due diligence investigation and the execution of definitive contracts, contemplates that the Plan may become a wholly owned subsidiary of the DMC and the DMC may provide contributed capital of $13.3 million, thereby increasing the Plan's net worth and working capital. The cash received in the transaction may be used to pay medical claims. Further, if the contemplated transaction is consummated the UAHC Board of Directors authorized the forgiveness or conversion to a surplus note of $4.7 million due UAHC at December 31, 2000 for accrued management fees and a previous advance provided to the Plan.

Under new regulations issued by the Michigan Division of Insurance in June 2000, HMOs are required to meet new net worth requirements on or before December 31, 2003. The requirement is the greater of $1.5 million, three months of uncovered expenditures, or 4% of annual subscription revenue. If a higher level is achieved prior to December 31, 2003, that level is required to be maintained.

At December 31, 2000, the Plan was required to meet the $1.5 million net worth requirement. Under the greater requirement of 4% of annual subscription revenue, approximately $6.8 million of net worth would have been required for the year ended December 31, 2000. Furthermore, the NAIC introduced additional measurements of the minimum amount of capital appropriate for managed care organizations known as Risk Based Capital (RBC) in 1998 to provide State Insurance Regulators additional standardized levels of action. The Letter provides for an action plan for the Plan to obtain a 200% RBC level prior to December 31, 2001.

During 2000, the Plan's medical loss ratio (MLR) was 94%. The Medicaid MLR was 89% for the year ended December 31, 2000, while the commercial MLR was 104%. In an effort to reduce the medical loss ratio, throughout the year the Plan implemented rate increases, particularly for the Plan's OmniCare Plus members, re-negotiated prior years' physician and hospital contracts, and in October 2000, changed its pharmacy benefit manager (PBM), thereby reducing prescription and pharmacy administration costs.

The Plan's losses from operations were also related to its contractual relationship with the State of Michigan on behalf of its Medicaid recipients, which accounted for approximately 67% of the Plan's revenues in 2000. During 1997, the State of Michigan, in an effort to reduce the cost of its Medicaid program, mandated HMO benefit plans for the majority of its Medicaid recipients and competitively bid its Medicaid contracts in Southeastern Michigan. The new Medicaid program, which commenced effective July 1997, reflected rate reductions of 20%; accordingly, the operating revenues of the Plan were adversely affected. In May 2000, the Plan re-bid for continued eligibility as an HMO providing coverage to enrollees of the State's Medicaid program and increased Medicaid rates. In July 2000, the State of Michigan notified the Plan that it was one of the successful bidders. As a result, the Plan received a new contract with the State through September 30, 2002, with the potential for three one-year contract extensions. The new contract also awarded the Plan an approximate 11% rate increase effective October 1, 2000, partially offset by the elimination of reimbursement for dual eligibles with the removal of such individuals as eligible enrollees. Concurrently, the State mandated increased fees be paid to providers who service Medicaid enrollees of between 4% and 11% with an overall increases of approximately 7%.

Beginning February 2000, the State's Comprehensive Health Care Program for Medicaid beneficiaries began partially reimbursing healthcare plans for costs spent on psychotropic medications for Medicaid beneficiaries. Further, effective October 1, 2000, the Plan received new reimbursement rates for Medicaid maternity cases, receiving a case rate for each maternity case immediately following the mother's delivery. Revenue for maternity cases was previously included in capitation, which had the effect of spreading the revenue over several years while the costs for maternity cases were included in a single year. The change in the reimbursement for maternity cases yields a more proper matching of revenue and the associated expenses in the same period.

In May 2000, the Plan's management company, UAHC, began implementation of a new strategic information technology plan intended to enhance the Plan's operations, support provider, member and employer information requirements and reduce the Plan's costs. The first phase of this plan, which was completed in October 2000, automated claims entry by scanning, imaging, and electronic data interchange. UAHC has entered into a licensing agreement, on the Plan's behalf, with OAO HealthCare Solutions to purchase a new computer system to replace the current processing and payment system. The new system includes many features and capabilities that must now be performed manually. Activities that will be automated via the new system include enrollment, benefits management, premium billing, claims and encounter processing, medical management, case management, quality management, referral management, provider contracting, and Health Plan Employer Data and information Set (HEDIS) reporting.

The effects of the new contract, including the rate increase, removal of dual eligibles as enrollees, and the new reimbursement practices for psychotropic drugs and maternity, are expected to reduce the Plan's Medicaid medical loss ratio. Increased commercial premiums, the new PBM and continued efforts to expand the provider network under more consistent and favorable contract terms are anticipated to reduce the commercial medical loss ratio. Further, the proposed letter with the DMC, if consummated, is anticipated to afford the Plan access to additional capital and the opportunity to create synergies to reduce medical and administrative costs and negotiate risk sharing contracts over an expanded provider base.

The financial statements do not include any adjustments that might result if the Plan is not successful in reducing its medical costs or provide for adequate sources of liquidity.

(3) Investments

At December 31, 2000, the Plan had investments in U.S. Government obligations, excluding amounts maintained under statutory requirements, which were carried at amortized cost, which approximates fair value.

Net investment income and gains on investments are comprised of the following for the year ended December 31, 2000:

Income:		
Interest	$	643
Realized losses, net		(26)
Net investment income	$	617

(4) Investment in Joint Venture

The Plan has a 60% interest in a joint venture with Blue Cross Blue Shield of Michigan, CasinoCare, LLC, which is accounted for under the equity method. The Plan offers its HMO product to employees of local casinos through this joint venture. The Plan does not have the capability to exert control over this joint venture entity, and further, the Plan's 60% ownership interest in this joint venture is temporary and will vary based on the membership levels of each partner.

(5) Provider Receivables

The following table provides detail of the components of provider receivables at December 31, 2000 (in thousands):

Provider chargebacks	$	2,131
Duplicate payments		3,692
Provider over payments		550
	$	6,373

(Continued)

(6) Medical Claims Payable

The following table provides a reconciliation of medical claims payable for the year ended December 31, 2000 (in thousands):

Balance at beginning of year	$	24,295
Incurred loss related to current year		160,170
Total loss incurred		160,170
Paid claims related to current year		134,083
Paid claims related to prior year		24,617
Issuance of surplus note (see note 7)		5,000
Total paid claims		163,700
Balance at end of year	$	20,765

(7) Surplus Notes

The following surplus notes are outstanding at December 31, 2000 (in thousands):

United American Healthcare Corporation, June 30, 1998	$	4,600
United American Healthcare Corporation, April 13, 2000		7,700
Detroit Medical Center, November 29, 2000		5,000
	$	17,300

On April 13, 2000, and June 30, 1998, UAHC funded unsecured loans to the Plan, evidenced by surplus notes of $7.7 million and $4.6 million, respectively, to enable the Plan to meet its statutory net worth and working capital requirements at that time. Interest is at 8.5% and prime rate, respectively, and payments, if any, are subject to approval by the Insurance Commissioner. The $7.7 million surplus note consisted of conversion of $3.7 million of accrued and unpaid management fees and $4.0 million cash to the Plan.

In November 2000, the Plan converted medical claims payable owed to the DMC to a surplus note in the amount of $5.0 million. Interest is at 8.5%, and payments, if any, are subject to approval by the Insurance Commissioner.

Under the terms of the surplus notes, interest and principal payments are subject to approval by the Insurance Commissioner and shall be repaid only out of the statutory surplus earnings of the Plan. For 2000, the Plan incurred no interest expense on these surplus notes.

(8) Related Party and Affiliated Transactions

The Plan has a management agreement with UAHC, effective through December 2005, whereby UAHC supervises and manages the operations of the Plan. The Plan has the option to renew the agreement for a succeeding five-year period through the year 2010 at mutually satisfactory terms. Management fee expense is computed as 14% of earned revenue. For the year ended December 31, 2000, management fee expense aggregated $22.5 million under this agreement.

In addition, UAHC is an employer group, which offers the Plan's healthcare coverage to its employees. For the year ended December 31, 2000, premium revenue earned from UAHC and its employees was approximately $778,000.

Certain members of the Plan's board of trustees provide services to the Plan at fair value, which totaled approximately $101,000 for the year ended December 31, 2000.

(9) Contingencies

The Plan is subject to extensive federal and state health care and insurance regulations designed primarily to protect enrollees, particularly with respect to government-sponsored enrollees. Such regulations govern many aspects of the Plan's business affairs and typically empower state agencies to review management agreements with health care plans for, among other things, reasonableness of charges. Among the other areas regulated by federal and state law are licensure requirements, premium rate increases, new product offerings, procedures for quality assurance, and the financial condition, including cash reserve requirements. There can be no assurances that the Plan will be granted the necessary approvals for new products or will maintain federal qualifications or state licensure.

The licensing and operation of the Plan are governed by the respective Michigan statutes and regulations applicable to HMOs. The Plan's license is subject to denial, limitation, suspension, or revocation if there is a determination that the Plan is operating out of compliance with the Michigan HMO statutes, failing to provide quality health services, establishing rates that are unfair or unreasonable, failing to fulfill obligations under outstanding agreements, or operating on an unsound fiscal basis.

The Plan is subject to the federal HMO Act. Federal and state regulation of health care plans is subject to frequent change and generally gives responsible administrative agencies broad discretion. Laws and regulations relating to the Plan's business are subject to amendment and/or interpretation. In particular, legislation mandating managed care for Medicaid recipients is often subject to change and may not initially be accompanied by administrative rules and guidelines. Changes in Federal or state governmental regulation could affect the Plan's operations, cash flows, and business prospects.

Newspaper stories in May 1998 reported that the Office had obtained a sealed (confidential) court order on May 7, 1998 giving state regulators control over the Plan's assets. The Plan responded with a public statement on May 12, 1998 stating that the Plan was not in receivership but was in active discussion with the Office regarding compliance with certain regulatory issues; that all services to members of the Plan would continue to be provided, with no decrease in quality of care; that all providers would continue to be paid for their services; and that the Plan had completely restructured its senior management. On July 1, 1998, the Office issued a public statement in which the Michigan Commissioner of Insurance announced reaching accord with the Plan to implement a corrective action plan to revitalize the HMO.

In April 1995, the Plan received a draft audit report from the United States Office of Personnel Management (OPM) as a result of their audit of the Plan performed for the Federal Employees Health Benefit Plan (FEHBP) for the years 1988-1992. In this draft report, the OPM asserted that the Plan owed a refund to the FEHBP for certain over-payments for those years. During 2000, it was determined that the OPM also owed the Plan amounts due as a result of a rate reconciliation performed in 2000. On April 24, 2001, the two parties settled the above issues, resulting in the Plan owing the OPM $1.8 million for the years 1988-1992, and the OPM owing the Plan $1.5 million for the 2000 rate reconciliation. The resulting net Plan liability of $0.3 million is included in accounts payable and accrued expenses at December 31, 2000 and, in accordance with the settlement, may be offset against amounts due the Plan resulting from the 2001 rate reconciliation.